City of Newton

Setti Warren
Mayor

**Health & Human Services Department**
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Public Health
Prevent. Promote. Protect.

# Student Flu Vaccine Consent and Screening Form 2011-12

| Child's Last Name | Child's First Name | Date of Birth | Age | Gender: ☐ M ☐ F |
|---|---|---|---|---|
| Parent/Guardian Last Name | Parent/Guardian First Name | | Parent/Guardian Phone | |
| SCHOOL NAME | | | GRADE | |

**Both the injectable flu shot and the nasal spray flu vaccine are available.**
**Please choose the vaccine you want your child to have by**
**circling your choice below, answering the screening questions, and signing at the bottom of the form.**
**If you are not sure of the answers to these questions, contact your child's health care provider.**

## INJECTABLE FLU SHOT circle one NASAL SPRAY FLU VACCINE

| | Yes | No |
|---|---|---|
| 1. Does your child have a problem eating eggs? | | |
| 2. Does your child have an allergy to gentamicin, neomycin, polymixin or gelatin? | | |
| 3. Has your child ever had a serious reaction to a previous dose of flu vaccine? | | |
| 4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine? | | |

I have read the 2011-2012 Vaccine Information Statement for the injectable influenza vaccine and understand the risks and benefits.
I GIVE CONSENT for my child to get vaccinated with this vaccine.

PARENT/GUARDIAN SIGNATURE:

_____ DATE: _____

**For children 6 months through 8 years old:**

Children in this age group who did not receive influenza vaccine last year should receive 2 doses of the 2011-2012 seasonal influenza vaccine at least 4 weeks apart.

Contact the child's primary health care provider to receive a second dose, or visit www.newtonma.gov/flu for additional clinics.

| | Yes | No |
|---|---|---|
| 1. Does your child have a problem eating eggs? | | |
| 2. Does your child have an allergy to gentamicin, neomycin, polymixin or gelatin? | | |
| 3. Has your child ever had a serious reaction to a previous dose of flu vaccine? | | |
| 4. Does your child have asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? | | |
| 5. If you child is younger than 5 years old, has a healthcare provider told you that your child had wheezing or asthma within the last 12 months? | | |
| 6. Does your child have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)? | | |
| 7. Is your child taking antiviral medications? | | |
| 8. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)? | | |
| 9. Is your child pregnant? | | |
| 4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine? | | |
| 11. Does your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)? | | |
| 12. Has your child received any other vaccinations (not just flu) in the past 30 days? Vaccine: _____ Date: ____/____/____ | | |

I have read the 2011-2012 Vaccine Information Statement for the nasal spray influenza vaccine and understand the risks and benefits.
I GIVE CONSENT for my child to get vaccinated with this vaccine.

PARENT/GUARDIAN SIGNATURE:

_____ DATE: _____